# A GIANT PEDUNCULATED TUMOR (FIBROLIPOMA) OF OESOPHAGUS - A RARE CASE

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**ABSTRACT :** *A giant pedunculate tumour of oesophagus is reported in this study for its rareness.*

*A male patient aged 48 years was admitted at Jorhat Christian Medical Centre with the complaint of swelling of the neck and dysphagia for a period of 4 months. Clinically the neck swelling looks like swelling of left lobe of thyroid with intrathoracic extension. ENT examination was normal. The barium Swallow X-ray of oesophagus showed surprisingly huge dilatation of upper half of the oesophagus. The oesophagoscopy showed a large mobile intra oesophageal tumour extending from the upper end of the oesophagus upto the mid thoracic region. The neck is explored by collar incission and the cervical oesophagus is opened by longitudinal incission. The tumour is pulled out from the oesophagus and is removed completely by cutting the peduncle which was attached to the right wall of the oesophagus just below the cricopharynx. The peduncle was about 1 cm in diameter., The length of the tumour was about 3-4 cm at the thoracic part. Post Operative recovery was uneventful. The histopathology report showed it to be a case of FIBROLIPOMA.*

***Key Words : Oesophagus, Pedunculate Giant Fibrolipoma.***

## INTRODUCTION

Giant Pedunculated Oesophageal tumours (Polyps) are very rare. They constitute less than 1% of total oesophageal tumours (Lakhkar, B. N., 1991, Wolfensberger, M. 1995). They may remain asymptomatic for a long time and first come to the attention of the patient and the clinician after regurgitation into the mouth. Regurgitation, however, may be dangerous and has been known to lead to asphyxia and death due to closure of the larynx by the tumour mass. Aetiology is unknown, 75% of all the cases are male in between 40 to 70 years of age. These are best diagnosed by endoscopy and/or radiography. They can arise from any part of the oesophagus but most common site is cervical oesophagus near the cricopharynx.

Different authors have reported a number of cases of pedunculated tumours of oesophagus in different literature at different times. These include fibrovascular polyp, lipoma, hamartoma, liposarcoma, carcinoma, leiomyoma, adenoid cystic carcinoma, carcinosarcoma, hemolymphangioma, angiolipofibroma etc.

Van Lanschot J. J. et al, (1987) reported two cases of benign pedunculated tumors of oesophagus who only complained of reappearance of the tumor in their mouths,

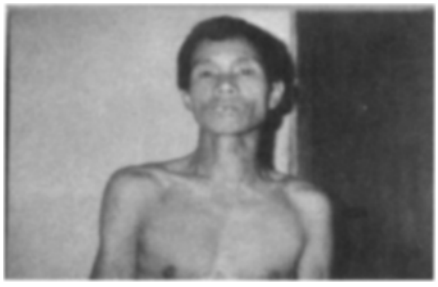

Fig. I : The patient Mr. M. Phom, 48 yrs, m,ch. Pre-Operative photograph of the patient showing the prominent Anterior Neck Swelling.

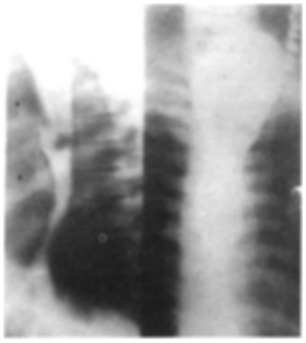

Fig-II : Pre-Operative -Ba-Swallow X-ray of Oesphagus showing the huge dilatation of Cervical Oesophagus extending to the mid thoracic region.

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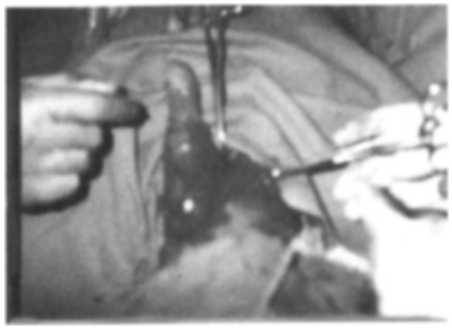

Fig-III : Intra-Operative-The tumour is pulled out from the oesophageal lumen but still attached to the oesophageal wall by the peduncle.

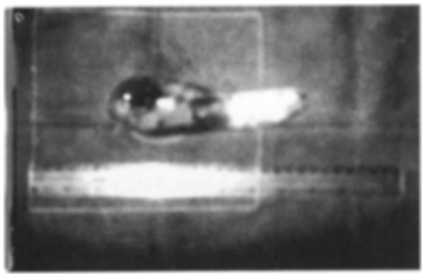

Fig-IV : Post-Operative -The tumour after removal

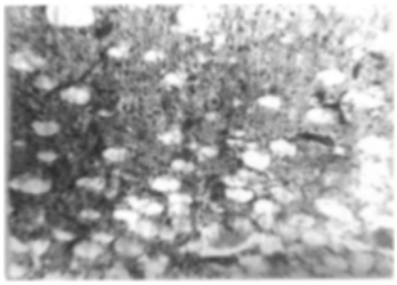

Fig-V : Post -Operative - Histopathology of the tumour showing characteristics of Fibrolipoma.

Bak Y.T. et al, (1989) reported a giant pedunculated liposarcoma which was 20 cm. long and 7 cm. in average diameter with the stock measuring 3 cm long and 1 cm. in diameter. Giani A. Z. et al, (1998) reported 4 cases of giant oesophageal polyp, the histological diagnosis of which were fibrovascular polyp, liposarcoma, hamartoma and multiple lipoma. Gupta N. M. et al, (1998) reported a case of pedunculated large leiomyoma of oesophagus which was 20 cm. long. Paraf F. et al, (1992) reported 3 cases of pedunculated tumours of Barrett oesophagus which were found to be adenocarcinoma.

## CASE REPORT

A male patient aged 48 years from Nagaland reported in ENT OPD of Jorhat Christian Medical Centre, Jorhat with the complaint of dysphagia and swelling of anterior neck just left to the midline since four months. Clinical examination revealed his ear, nose and throat to be normal. Swelling which appeared to be arising from left lobe of thyroid was firm on palpation, fairly mobile, and had an intrathoracic extension. Our provisional diagnosis was a swelling of the left lobe of thyroid having intrathoracic extension. We were not sure of whether the dysphagia was a separate entity or resulted due to the swelling itself.

A Barium swallow X-Ray of oesophagus was done which surprisingly showed a huge dilation of the upper half of the oesophagus. The dilation was maximum in the cervical oesophagus which then tailed off at the level of the midthoracic region.

Routine examination of blood, stool, urine and chest X-Ray revealed no abnormalities. We did oesophagoscopy of the patient under GA and came across a big mass in the oesopgagus. Interestingly, the oesophagoscope could easily pass between the mass and the posterior wall of the oesophagus. We had also observed that the mass was attached to the right wall of the cervical oesophagus by a peduncle the size of which, however, could not be assessed. The lower tapering end of the mass was also seen hanging in the middle third of the oesophagus. finally we concluded that there was a big pedunculated intraoesophageal tumour pressing over its wall causing a neck swelling.

A plan to explore the mass through the neck was made. A collar incision was made to approach the left lobe of the thyroid. We found that the size and shape of the lobe was normal but there was adhesion of it with the swelling. Thyroid vessels of the left side were ligated and the left lobe was everted medially. The wall of the oesophagus was exposed where we made longitudinal incision measuring about 5 cm. Index finger was passed through the incision in between the inner oesophageal wall and the tumour and the later was pulled out en mass by hooking the index finger around it. The peduncle was found to be attached to the right wall of the oesophagus just below the cricopharynx. It was detached from the wall by cutting diathermy. Haemostasis was achieved and oesophageal wall was repaired by 2.0 vicryl suture. The wound was repaired in layers and the patient was put on Nasogastric Tube Feeding.

The peduncle measured about 1 cm in diameter and the

length of the tumour was about 17 cm. While the diameter in the cervical part was 6 to 7 cm. the same was 3 to 4 cm in the thoracic part. Post operative recovery was uneventful and patient was allowed to take liquid diet from 4th day onward.

Post operative barium swallow oesophagus showed normal passage of barium with slight dilation on the upper on third.

The histopathology examination showed it to be Fibrolipoma.

## DISCUSSION

Pedunculated tumours of oesophagus are rare. As the commonest cause of dysphagia in an adult is carcinoma of the oesophagus, our first impression in this particular case was also Ca-oesophagus with goitre. But contrary to our belief, Ba-swallow interestingly revealed a huge dialation of the cervical oesophagus. The diagnosis was even doubtful after oesophagoscopy because it was not possible to assess the complete size, shape and attachment of the tumour because of its huge size. Surgery was the only treatment which we planned with some hesitation, but ultimately felt great satisfaction for being able to remove the tumour completely without any complication.

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# PROGNOMA OF MAXILLA


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**ABSTRACT :** *Prognoma is a rare dysembryogenic tumour of infancy. Very few cases have been recorded in the world literature so far. A case report of this tumour affecting a female child with involvement of the right maxilla is being presented. Histopathologically prognoma is a melanotic neuroectodermal tumour. An increased level of a-fetoprotein in the serum and vanillylmendilic acid (V.M.A.) in a 24 hours urine sample have been reported with prognoma.*


## CASE REPORT

A four month old female child was brought to ENT out patient department of NRS Medical College with the complaint of a progressively increasing swelling involving the right half of the hard palate, alveolus and malar area. It was smooth, globular, firm to hard in consistency protruding into the oral cavity (Fig.I), The colour of the tumour was pale pink. The airway of the right nasal cavity was found be compromised due to local mechanical obstruction. The right eye showed slight proptosis with normal movement and vision. Cranial nerves were however intact.

The routine haemogram was normal, X-ray PNS (Water's view) showed obliteration of the maxillary sinus on the right side with bony expansion of the alveolus and the


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